Richmond and Wandsworth Safeguarding Adults Board

RICHMOND AND WANDSWORTH SAFEGUARDING ADULTS BOARD

Annual Report 2023-2024

Richmond and Wandsworth Safeguarding Adults Board

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FOREWORD FROM THE INDEPENDENT CHAIR OF THE RICHMOND AND WANDSWORTH SAFEGUARDING ADULTS BOARD

I am pleased to introduce the Richmond and Wandsworth Safeguarding Adults Board Annual Report for 2023-2024 which highlights the multi-agency strategic partnership work to promote awareness of safeguarding adults and to ensure adults at risk are effectively protected. Learning lessons when multi-agency work goes wrong from both local and national reports has been a key priority as has strengthening assurance on learning and the quality of interventions.

All SABs have to have an annual strategy, in RWSAB the annual business plan is based on a 5-year strategic plan which needed review in September 2023 for a new 5-year strategy. One of our objectives was to engage with people with lived experience and local diverse groups for views on shaping the strategy, so a consultation was undertaken, and the final strategic priorities were agreed for April 2024 and have been included in this report.

As part of this review the SAB Executive recognised the need to also review the Joint Board functioning and governance following some feedback on the need to strengthen the partners' work together in the respective councils' areas, with different population and diversity needs.

A survey of partners found very positive feedback on the joint strategic arrangements but also welcomed a more specific focus on each council's population's safeguarding needs. The final agreement by the Executive has resulted in a strategic safeguarding partnership for each council commenced in November 2023. They will each be responsible for local strategic priorities, local assurance and ensuring the voice of local people are represented in the work priorities.

As ever, Safeguarding priorities reflect both local, regional and national issues, and in 2023-2024 we saw the impact of the Cost-of-Living Crisis, Financial abuse, Fire Safety concerns, domestic abuse, modern slavery. Statutory agencies, police, health and local authority were impacted with increasing demand, higher levels of need and significant workforce issues. In particular post Covid an increased number of homeless people and rough sleepers led to new strategic approaches working with housing homelessness partners, learning from London-wide Safeguarding adults reviews and multi-agency support. The way in which the national asylum seekers support changed impacted work with refugees, and the SAB health and social care partners worked hard to ensure local safeguarding was well understood with Home Office agencies responsible.

Specific issues which differed for the council areas were in Richmond, with a high number of

registered care providers to ensure safeguarding training through commissioning was promoted. This led to concerns about the high number of small charity groups providing advice and other services and how to ensure the Richmond Community Forum could promote awareness of safeguarding. This will be developed in 2024/25. In Wandsworth, with a growing younger population, raising awareness of safeguarding and mental health needs and diversity are a priority, with the Wandsworth Community Forum needing to work more effectively together to engage with local communities.

Whilst good progress was made in making links with Wandsworth Prison, following critical HM Prison and CQC Inspections, the SAB role is different and limited, to support understanding of safeguarding. This work has been delayed due to staff changes in the prison and other resource issues. Nonetheless a task and finish group was established to reach agreement on a broader Criminal Justice framework for safeguarding and pathways including community safety and probation.

This report summarises key data, the evidence for the SAB to measure its effectiveness and the separate data on a page provides an easy read to the quantity and impact of what the SAB does, It also provides the evidence of where there are gaps in reporting and identifying different groups to raise awareness.

The quality of multi-agency safeguarding is equally important and the data on satisfaction and Making Safeguarding Personal shows the effectiveness of work with people going through the safeguarding process. But it is the richness of case analysis that is important to show both the strengths and weaknesses of practise that more training may be required, such as application of the Mental Capacity Act, professional curiosity and trauma-informed practice.

Developing links and integrating safeguarding priorities with other partnerships is key. An ambitious partnership has been forged with Kingston SAB, Kingston and Richmond Children's Partnership and respective Kingston and Richmond Community Safety Leads to agree a framework to align learning from children's reviews, domestic homicide reviews and SARs.

As Vice-Chair I participate in the London SAB network and learning from homelessness reviews and fire safety SARs has been reflected locally as well as though the Chairs' group for South-West London. The National Chairs network now hosts the National SAR repository of all SARs to enable learning from other regions.

I also participated in a national Criminal Justice Chairs' group to explore and develop a framework to use to promote safeguarding with local criminal justice partners. I referred above to our SAB's joint new 5-year strategic plan, which is reviewed annually to reflect different concerns and priorities as they emerge. 3 key priorities for 2024/25 are based on promoting awareness of safeguarding, more effective engagement with People with lived Experience and Community groups to influence the SAB work, and developing effective assurance of learning from SARs, using the second National SAR review, aligning joint priorities, such as transitional safeguarding for 18-25 with the respective children's partnerships and community safety to have a clear focus on the specific issues for those leaving care, homelessness and substance misuse.

All of this has required huge commitment from our partners, and I would like to thank the many agencies and individuals who have helped the SAB contribute to promoting safeguarding of adults in Richmond and Wandsworth.

Christabel Shawcross
Chair of Richmond and Wandsworth Safeguarding Adults Board

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INTRODUCTION

Richmond and Wandsworth Safeguarding Adults Board

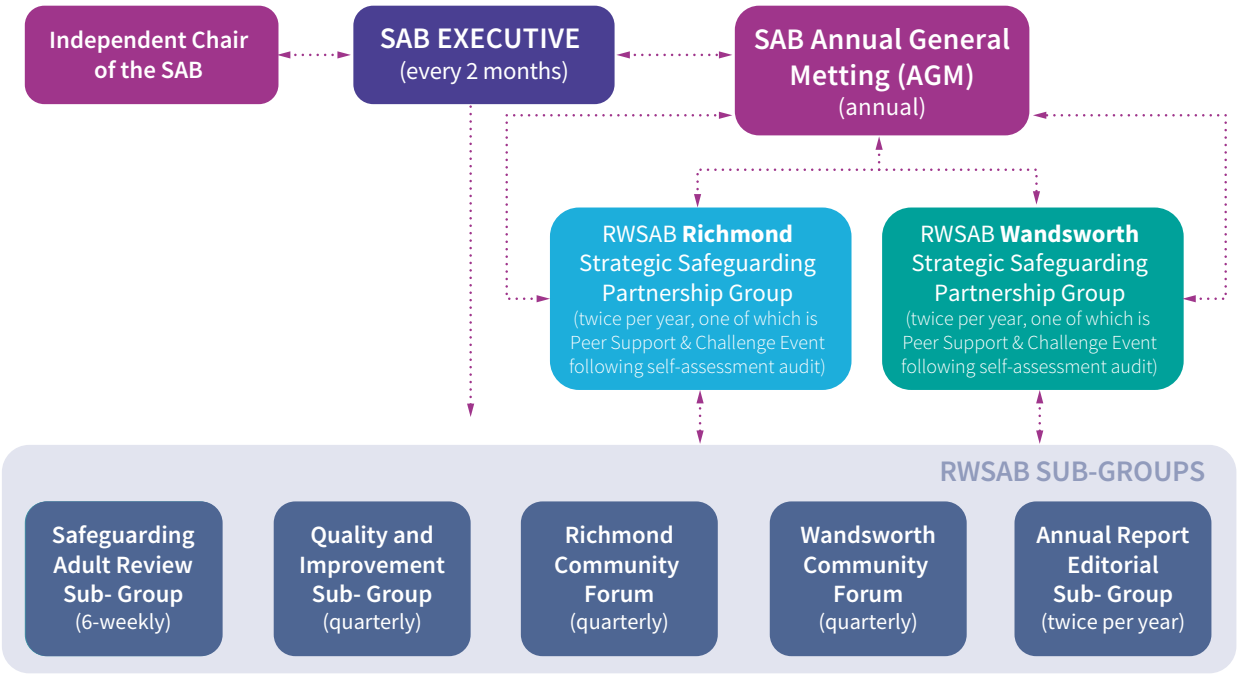
Setting up a Safeguarding Adults Board (SAB) with key statutory partners, (i.e. local police and Integrated Care Board) is a requirement for the Local Authority set out in Section 43 of the Care Act 2014. Its main objective is to ensure that safeguarding arrangements across the partnership work effectively to prevent abuse and neglect, and to protect people with care and support needs, who may be at risk of abuse and neglect.

The Richmond and Wandsworth Safeguarding Adults Board (RWSAB) brings together a wide group of organisations and communities, who are working together effectively so people can live their lives free from abuse or neglect. It does this by:

- Working collaboratively to prevent abuse and neglect.
- Ensuring agencies and individuals give timely and proportionate responses when abuse or neglect has occurred.
- Seeking assurance that local safeguarding arrangements are in place as defined by the Care Act 2014 and statutory guidance.
- Seeking assurance that safeguarding practice is person-centered and outcome focused.
- Seeking assurance that safeguarding practice is continuously improving and enhancing the quality of life of adults in its area.

This report provides safeguarding data for Richmond and Wandsworth, information on how safeguarding is monitored, how the Board and its partners have worked and information on what we have achieved on our strategic priorities throughout the year.

Structure of the RWSAB



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2023 GOVERNANCE REVIEW OF THE RWSAB

Richmond and Wandsworth Safeguarding Adults Board

In 2023–2024, the Joint Richmond and Wandsworth Safeguarding Adults Board implemented a revised governance structure.

The areas for development considered included whether there was a need for more challenge from wider strategic partners, more focus on the specific needs of each Borough within the shared SAB arrangements or better opportunities for involvement of the Lead Elected Members in the work of the RWSAB.

A Survey was sent to each agency to gauge how involved they felt and if any major gaps in current engagement were identified across the wider partnership. A total of 30 agencies were surveyed, of which 27 responses were received. Feedback from the survey showed that partners felt well informed, well connected, and engaged with the Board; events and communications from the Board were good; most partners felt there was enough local focus, but more work was needed to include diverse groups and experts by experience. Workforce capacity was a major consideration in engagement with the work of the Board.

This informed the options for consideration and together with some practical amendments to the sub-groups' schedules, the SAB Executive decided to implement two additional meetings, one for each Borough, to review the achievements on the Business Plan, take stock of where the local partnership is at and if anything needs more specific focus. These meetings were named Richmond/Wandsworth Strategic Safeguarding Partnership Group and together with the Peer Support & Challenge Events, the Annual General meeting and the Annual Self-assessment Questionnaire form the cycle of governance for the RWSAB.

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DEVELOP STRATEGIC FRAMEWORKS FOR LEARNING WITH KEY PARTNERS

Richmond and Wandsworth Safeguarding Adults Board

The Richmond and Wandsworth Safeguarding Adults Board has been working with partners to establish ways of sharing learning from the reviews we each are responsible for – this includes Community Safety with Domestic Homicide Reviews, Safeguarding Children Partnerships for Child Safeguarding Practice Reviews, and the SAB with Safeguarding Adults Reviews.

A Safeguarding Interface Meeting was newly established across Kingston and Richmond and including strategic involvement from the Kingston and Richmond Safeguarding Children Partnership, Achieving for Children (covering Richmond and Kingston), the Safeguarding Adults Boards in each area, and Community Safety in both Boroughs. This group's aim is to support multi-agency communication and to promote an aligned approach to key priorities and associated areas of work.

The South-West London Safeguarding Adults Board Chairs and Managers meet quarterly to develop consistency of approach between SABs on key issues of mutual concern and to collaborate and develop SAB processes and joint learning across South-West London SABs.

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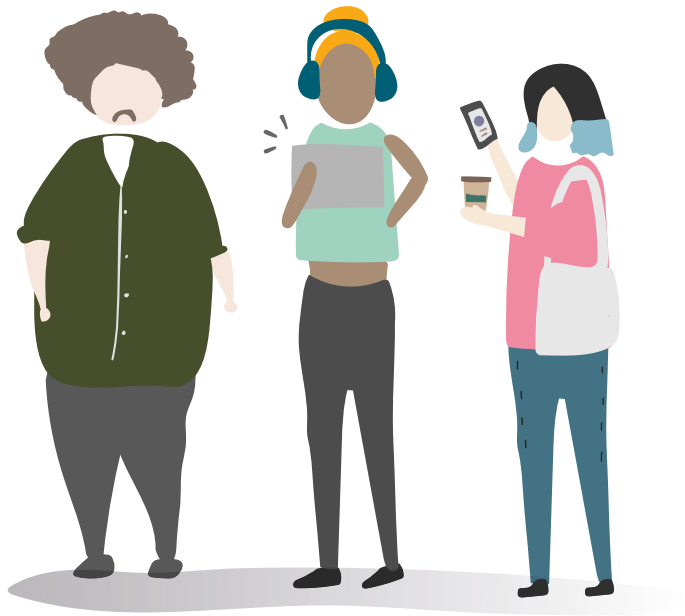
WORK OF THE SUB-GROUPS AND REVIEW OF THE BOARD'S BUSINESS PLAN 2023/24



Richmond and Wandsworth Safeguarding Adults Board

SUB-GROUP ACTIVITIES 2023/24

While the SAB Executive oversees the implementation of the Board's strategy, the sub-groups carry out much of the practical work. They are the engines behind the Board. This section sets out the work and achievements of each sub-group.

SAB Executive

This group is formed of the three core partners of the SAB – Local Authority, Police and Integrated Care Board. It oversees the strategic direction of the RWSAB and signs off final policies, SAR reports and strategic documents like the Business Plan.

The SAB Executive monitored and oversaw the RWSAB budget and risk log, implemented the amended Governance structure and oversaw the continuous development of the sub-groups.

They also signed off updated terms of reference for the SAB, Executive and the sub-groups following the Governance review.

The following topics were presented and discussed for assurance and to identify any issues at the Executive throughout the year:

- Asylum Seekers
- Update on Advanced Customer Support service covering Safeguarding in DWP
- Update on the Richmond and Kingston Vulnerable Adolescents Supported into Adulthood (VASA) Panel
- Right Care Right Person
- CQC Quality Assurance Framework for Local Authorities updates.
- Yearly update from CQC on the quality of Adult Social Care and Health provision in Richmond and in Wandsworth.

Quality and Improvement Sub-group

The Quality and Improvement sub-group supports the Board in providing a strategic overview of the quality of safeguarding activity within the Boroughs. The group meets quarterly, with representation and assurance provided by core partners.

Performance

- Monitored performance via the Performance Dashboard and compared types of abuse with ethnicity, age and service user groups. This requires further consideration and will be repeated in 2024/25 to identify areas and groups which need further consultation.
- Had a comprehensive update on Homelessness and rough sleeper initiatives, and on safeguarding cases for people with no fixed abode.

Service Users feedback

- Feedback at the end of the Safeguarding Process remains a challenge to obtain. Numbers continue to be low, however the feedback is positive, and highlighting good communication and engagement with people and their family or advocates.

Quality and Improvement Sub-group continued

Learning and training

- Organised masterclasses on Tech Abuse in October 2023, which were attended by over 60 participants from a wide range of agencies, including voluntary sector.
- Agreed to have regular updates from key partners around compliance with training and agreed further focus needed around Mental Capacity Act.
- Sent out the Safeguarding Adults Partnership Assessment Tool (SAPAT) audit in November 2023 and held Peer Support and Challenge Events for each Borough in February 2024.

SAR Sub-group

Met regularly and considered four SAR referrals, one of which (in Richmond) met the mandatory criteria for a SAR and is currently underway.

Followed up on action plans from SARs, finalising the Cuckooing Multi-Agency Guidance, which was a long-outstanding action from the Michael SAR.

Considered Regulation 28 Coroner's Prevention of Future Deaths reports with recommendations for partners in Wandsworth and received updates and assurance on how they have been addressed from the relevant partners.

Considered and disseminated learnings from DHRs, children's reviews and SARs from other Boroughs with themes around Transitions and Fabricated or Induced Illness, which have also been shared widely across the RWSAB.

Richmond and Wandsworth Community Forums

The Community Forums in Richmond and Wandsworth are the main multi-agency meetings for each local area, involving wider representation from the local voluntary services and focussing on local Safeguarding issues. The Forums this year worked together to organise communications and promoted events for National Safeguarding Adults Week 2023, which provided professionals and volunteers with an opportunity to update themselves on relevant best practice.

Both Forums regularly considered the Performance Dashboard from local Borough-based perspective, and as a result the Local Authority did deep-dive audits (Homelessness, Sexual Health in Learning Disabilities), which found good Multi-disciplinary working, appropriate referrals and supporting Learning Disability residents on staying safe on-line.

Both Forums worked to disseminate messages on recent Scams from Trading Standards and heard updates from the Refugees Service for clarity on safeguarding training and any issues arising.

Richmond Community Forum worked together to create, consult on and share the Safeguarding Process Easy-Read leaflet, which received good feedback from focused Learning Disabilities Service User Groups and is now on the SAB website.

Our efforts to provide different options for learning from SARs previously provided the podcasts, which have been used by some partners to lead conversations with staff on topics in an "elevenses"-style of short, 1-hour targeted discussions. The feedback from those have been positive and the generated discussions rich with reflection and personal experiences. The aims to create further resources did not pan out this year, in part due to not having newly published SARs to explore.

Business Plan achievements

Some significant achievements in relation to the priorities in our Strategic Plan are:

Prevention and early intervention

- We created short videos for the public raising awareness on the topics of Self-neglect and Hate Crime, with the aim to provide another way to inform the public on how to recognise and report them. We are monitoring the data to see if this results in more referrals.
- We raised awareness with multi-agency professionals around Tech Abuse, the new Modern Slavery pathway, the framework on Controlling and Coercive behaviour, the Principles of Engagement and the updated Multi-agency Risk Assessment Framework. We received positive feedback and professionals said these resources have helped them in their day-to-day practice.
- We are working with wider partners in a Criminal Justice Task & Finish Group to create a Wandsworth Multi-agency Framework for Safeguarding in the Criminal Justice System, aiming to promote better engagement with the Prison and services supporting release and reintegration of prisoners.

Making Safeguarding Personal

- We looked at homelessness and rough sleepers, how services are engaging with them and new initiatives, as well as the Safeguarding concerns for people with no fixed abode. Overall, this assured us of a good and improving service for rough sleepers in the two Boroughs, and that Safeguarding concerns are dealt with appropriately, with good Multi-disciplinary working and relevant signposting.
- We've started reaching out to existing service user groups and consulted on our Strategic Priorities and the Safeguarding Process Easy-read leaflet. It received positive feedback from both professionals and service users with learning disability and autism, who said they felt much better informed about safeguarding and the process, albeit some terminology was new to them and had to be explained (e.g. safeguarding Enquiry Officer).
- Continued efforts to get more feedback at the end of the Safeguarding Process. Numbers continue to be low, however the feedback is positive, and highlighting good communication and engagement with people and their family or advocates.
- Kept partners informed on the developments of the Liberty Protection Safeguards, which is no longer going ahead, through articles in the Newsletter and verbal updates at sub-groups.

Quality assurance on learning lessons and shaping practice

- Produced a regular Newsletter with useful information to enhance understanding and promote good practice. The Newsletter has received positive feedback from the partnership and other SAB Business Managers across South-West London.
- Promoted sharing of best practice, tools and materials to practitioners across the partnership via the Newsletter and direct emails.
- Considered learnings from the wider system – from DHRs, Children Reviews, Coroners prevention of future deaths reports, which have provided us with assurance that issues are addressed accordingly and with an opportunity to consider implications for the RWSAB from other reviews. As a result we have been working more closely with Children's Partnership to improve how learning is shared across to adults.
- Vulnerable Adolescents Supported into Adulthood Panel in Richmond, with planned joint audits in both Richmond and Wandsworth to ensure the updated Transitions protocol is working effectively.

The Richmond Community Forum had hoped to explore an option of sending text messages from GP practices to patients on how to report issues like Domestic Abuse/Mental Health, Discriminatory Abuse, Modern Slavery and other types of abuse, however this was deemed not feasible due to concerns around confidentiality.

The Board's work around a multi-agency Criminal Justice Safeguarding Framework is still ongoing, following personnel changes in Prison, which have delayed completion. This work will be continued in 2024/25.

The above achievements were discussed at the RWSAB's Annual General Meeting (AGM) in March 2024, and the new Business Plan was developed by the partnership.

Following a year of consultation with Older People's Forum, Carers Strategy Reference Groups, Community Safety Partnership and members of the RWSAB, the Board also agreed at the AGM the partnership's strategic priorities for the next 5 years, which provides overall outcomes to help guide the activities agreed for our yearly Business Plans.

Richmond and Wandsworth Safeguarding Adults Board

RWSAB Strategic Priorities 2024-2029

Strategic Priority 1

Prevention and Early Intervention

Desired outcomes:

- Adults from local communities are aware of what abuse is and how to keep themselves and those they care for safe.
- Partners, service users, residents and carers recognise risk and are confident in how to report it.

Strategic Priority 2

Making Safeguarding Personal

Desired outcomes:

- People are listened to and have real choice and control in shaping their safeguarding journey.
- Safeguarding practice is person-centred, and outcomes focussed.
- The voice of Richmond and Wandsworth residents is being heard and acted upon.

Strategic Priority 3

Quality Assurance and Embedding Learning

Desired outcomes:

- We learn from when things go wrong, both locally and nationally, and take appropriate action to reduce risks.
- We use learning to enhance practice across the partnership.
- The RWSAB has robust multi-agency safeguarding data which is used to inform planning and practice.

Strategic Priority 4

Cross-Sector Working

Desired outcomes:

- Vulnerable young adults are transitioning safely into adult services, including preparing for adulthood workstreams in Richmond and Wandsworth.
- Maintain links with other strategic partnerships across shared priorities.

Glossary of Safeguarding Adults Terms can be found on our website in the Annual Reports section.

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RICHMOND AND WANDSWORTH PERFORMANCE INFORMATION

Richmond and Wandsworth Safeguarding Adults Board

RICHMOND

195,278*
Borough population

16.5%
Black, Asian and Mixed Ethnicity

16%
Older people (65+)

*As per 2021 Census

Safeguarding in numbers – Safeguarding figures

Safeguarding Concerns and Enquiries

There has been an increase in both number of concerns (up by 8%) and enquiries (up 7%) in Richmond. The number of concerns which progress to enquiries has remained similar at 25%, which is on par with the average rate for London, and 91% of the enquiries were completed within the year. Enquiries not completed within the year were raised and logged close to the end of the year, taking their timelines for completion into next financial year.

The percentage of sex, and ethnicity-related enquiries is consistent with the population of the borough (over 83% of Richmond's population is white, and it is split 52% female and 48% male, with the proportion of females rising with age), however even though it is noted that Richmond upon Thames has the highest percentage of people over 40 in London, there was still an increase of cases relating to people over 85. This was due in part to an increase of cases in nursing homes, which are being investigated in more detail by the safeguarding team.

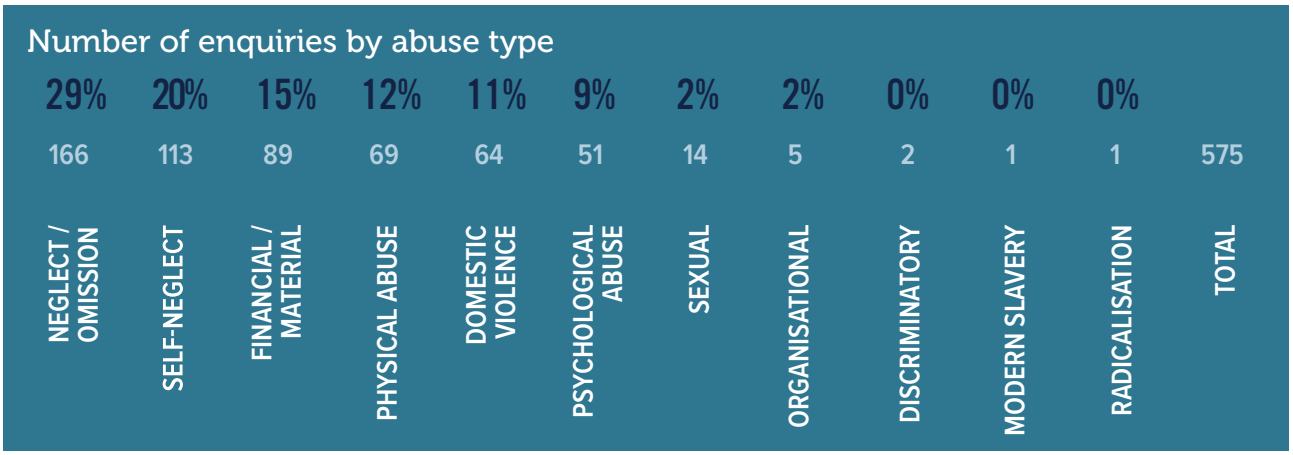
Since most people reside in their own homes, the majority of abuse occurs there (56%), which is consistent with both the national and regional average. There are 43 care facilities in Richmond upon Thames, which is reflected in the second-highest rate of abuse (25%) happening in residential and nursing care homes.

Half of the cases (50%) involved people who receive physical support. People who receive support with memory and cognition represented 14%, people requiring Learning Disabilities support – 13% of cases, and people with Mental Health support – 11%.

Types of Abuse

Over the past five years, the most common type of abuse documented has been Neglect or Acts of Omission. This is understandable given that the category includes a wide range of aspects. Neglect/Acts of Omission in 2023/24 made up 29% (up from 24% in 2022/23) of enquiries. Over the past three years, there has been a consistent rise in Self-Neglect, keeping it in second place (the overall number has stayed the same from previous year). Like in prior years, Financial/

Number of enquiries by abuse type



Material Abuse and Physical Abuse rank among the top four categories of abuse, with Financial/ Material going up 3% from 12% in 2022/23 to 15% in 2023/24. The RWSAB has raised awareness of the new Modern Slavery pathway in 2023/24, but levels of Discriminatory Abuse and Modern Slavery continue to be low.

Making Safeguarding Personal

All agencies performing safeguarding duties are mandated by the Care Act of 2014 to implement Making Safeguarding Personal (MSP), a sector-led strategy that aims to develop outcomes focus to safeguarding work. This means that all safeguarding activities should be person-led, outcome-oriented, supportive of participation, choice, and control, enhance the individual's quality of life, and advance safety and well-being.

How well the person's desired outcomes are met is one of the key performance metrics of the Making Safeguarding Personal. Safeguarding practice is person-centred and adheres to MSP principles; locally, 83% of those participating in a Safeguarding Enquiry stated desired outcomes, and 96% of those outcomes were fully (74%) or partially (22%) met. When results are not expressed or not met, it is typically because the individual did not wish to participate in the process or was ill at the time of the inquiry.

All 155 people lacking capacity had support from family, friend or advocate during the Safeguarding process.

Impact on risk and sense of safety

The London Borough of Richmond upon Thames has continually asked people and/or their representatives about whether they felt safer as a result of the assistance received from those attending to the safeguarding enquiry. Out of 456 completed enquiries, 374 people (82%) expressed they felt safer after the process. In the remaining 82 (18%) cases, due to the nature of the concern and the impact on the person, their sense of safety has not improved. These cases are monitored to ensure risk is managed.

The goal of adult safeguarding is to minimise or eliminate the risk to the adult. In 96% of cases, safeguarding reduced or removed the risk. Where the risk remains, it is typically because people have chosen to accept it and are aware of its consequences.

Concerns received in 2023/24

1970

8% increase
(1821 in 2022/23)

Enquiries in 2023/24

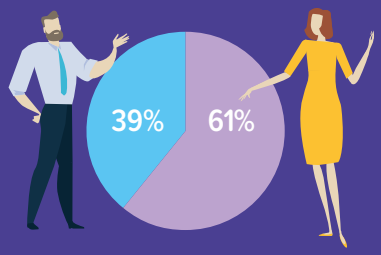
502

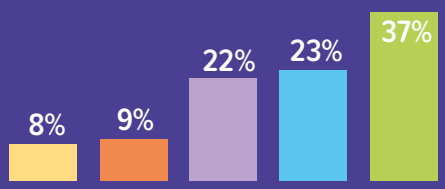
7% increase
(469 in 2022/23)

Conversion from concerns to enquiries

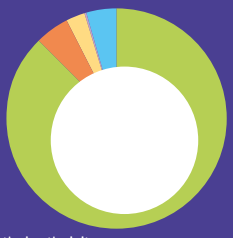
25%

26% in 2022/23





87.5% White
4.9% Asian
2.7% Black
0.2% Mixed
4.4% Other Ethnic Groups



1 person did not state their ethnicity

TYPES OF ABUSE

29% (166)
Neglect/Omission

Self-neglect
20% (113)

15% (89)
Financial/Material

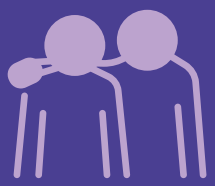
Physical
12% (69)

56% (229)
Own Home

25% (101)
Care Home Residential and Nursing

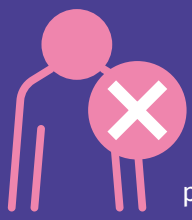
6% (23)
In the community
(excluding community services)

36% (165)
Known to Individual



9% (42)
Care, health or other Professional

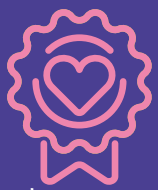
1% (2)
Not known to Individual



54% (247)
No alleged person recorded

82.7% (377)
Expressed Desired Outcomes

96% (362)
Outcome fully or partially achieved



82% (374)
Felt safer after safeguarding

96% (361)
Risk Reduced or removed

100%
Support from advocate, family or friend

Case study*

Mr Jones is a 75-year-old British man who until recently was living alone in a privately rented flat in Richmond. Mr Jones was receiving a daily visit from a home care agency to help him at home.

In July 2023, he became unwell, but declined to engage with health professionals. Mr Jones appeared to become anxious and suspicious of the doctor and the social worker, refusing home visits and phone calls, despite previously having a good relationship with them. His carers reported he had lost weight and that he would not let them support him with any of his personal care including maintaining his home environment, and at times not letting them into his flat at all. The Social Worker offered additional support, but he declined to accept this. Because of their concerns about Mr Jones neglecting his needs and environment and refusing help, the professionals raised a Safeguarding Concern for Mr Jones.

During this time Mr Jones had a fall and was taken to hospital and at that point more information was shared about Mr Jones' diagnosis of dementia which was likely having an impact on him engaging with local services and professionals. At the Safeguarding meeting with relevant partners and Mr Jones' relative Tristan acting as his advocate, it was agreed that Mr Jones was unable to recognise the relevant risks he was facing should he continue to decline support with his care needs. Even though Mr Jones was unable to express what he wanted support with, Tristan advocated for him and stated it was important that Mr Jones was safe and had the appropriate care.

Once Mr Jones was medically stable, a Mental Capacity Assessment was completed to determine if he could make an informed decision about where he should live upon discharge from hospital. Mr Jones was found to not have capacity and a Best Interest Decision with his advocate was made for Mr Jones to be discharged to a care home. Mr Jones has since settled in well at the care home, and reports enjoying having care staff available to help him when he needs it.

The Social Worker has taken the time to reflect on her learning and the value of having an advocate when a person is overwhelmed with what is happening and being supported to decide about where he should live, as well as the importance of working in partnership and thinking about Mr Jones's mental wellbeing as well as his physical health and safety when working with a resident who does not want to participate.

Tristan said:

> "As a relative, I found the safeguarding meeting very helpful, it meant everything could get out into the open and be discussed together. I appreciated how everyone acknowledged that this was a change for Mr Jones while being realistic about his needs and ability to cope at home."

Tristan felt that Mr Jones was safer and happier now in a care home.

*names and details may be changed to preserve the anonymity of the people involved

Richmond DoLS	22/23	%	23/24	%	Change 2022/23 to 2023/24	
Granted	515	63.1%	575	64.2%	+60	+12%
Not Granted	221	27.1%	244	27.2%	+23	+10%
Not yet signed off by Supervisory Body	80	9.8%	77	8.6%	-5	-6%
Total Number of Requests Received	816		896		78	

Deprivation of Liberty Safeguards (DoLS)

The total number of DoLS applications received in Richmond has continued to increase, and while the increase is slight (80 cases), it continues to demonstrate an upward trajectory. Performance has also increased with a rise in the number of authorisations granted, while the number of not granted has increased slightly, which demonstrates that most applications are appropriate – predominately authorisations not granted are as a result of people failing one of the qualifying assessments such as being assessed as having capacity or the person leaves hospital before the assessment process is completed or the person dies. All requested authorisations are reviewed, monitored, and triaged in accordance with the ADASS priority ensuring that the most urgent are prioritised. There is a process in place to guarantee renewals are addressed to minimise breaks in the authorisation. A summary of the number of Deprivation of Liberty Safeguards requests and authorisations in Richmond during 2023/24 is shown in the table above.

Community DoL

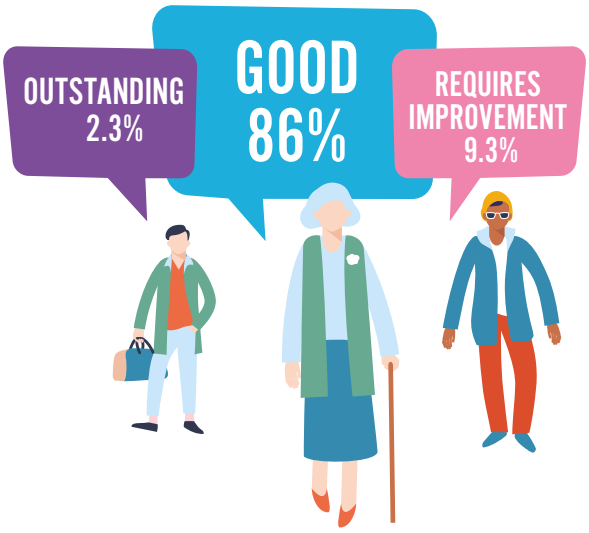
There be more focus on Community DoL this year and currently there are 88 people in the community in Richmond who are deprived of their liberty. These individuals are regularly reviewed and with those with highest levels of restriction, authorisation is granted by the Courts.

Provider Quality

In Richmond there are 43 local Care Homes and 19 Care-at-home Services Providers registered with the care regulator the Care Quality Commission (CQC). 37 Care Homes (86%) are rated Good by the CQC and one is outstanding. Four require improvement and one is rated inadequate, with action plans and regular quality monitoring by the Local Authority's Quality Assurance Team in place to help improve this rating. One of the Homecare Service Providers requires improvement and 16 (67%) are rated Good. There are seven new homecare providers which are not yet rated by the CQC, but the overall quality of both Care Home and Homecare services across the borough remains good.

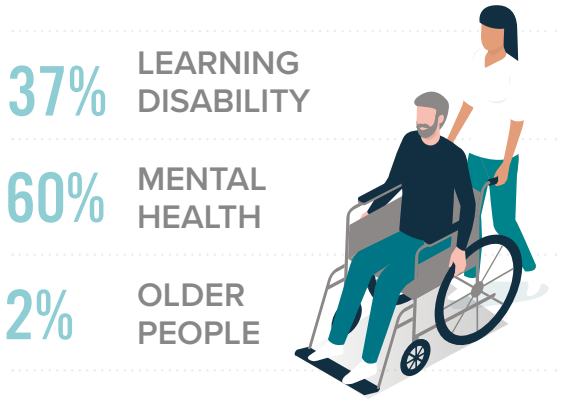
INADEQUATE 0%

Care-at-homes Services CQC Rating (Richmond)	No	%
Outstanding	0	0%
Good	16	67%
Requires improvement	1	4%
Inadequate	0	0%
Not yet rated	7	29%
Total	27	



INADEQUATE 2.3%

Care Homes CQC Rating (Richmond)	No	%
Outstanding	1	2.3%
Good	37	86.0%
Requires improvement	4	9.3%
Inadequate	1	2.3%
Total	43	



Care Home Type (Richmond)	No	%
Learning disabilities	16	37%
Mental health	26	60%
Older people	1	2%
Total	43	

Richmond and Wandsworth Safeguarding Adults Board

Learning from Lives and Deaths of people with a Learning Disability and Autistic People

Following a restructure within South-West London ICB and recommendation from The LeDeR Policy (2021) to have a dedicated team of Reviewers, two full time permanent reviewers' roles have now been recruited to. The new LeDeR Manger has been in post since April 2024 and the LeDeR Officer is due to commence, in role, in June 2024. Overall governance of the South-West London LeDeR Programme, at a strategic level, remains with the Chief Nurse and Director for Quality, who assigns the day-to-day operational management to the Local Area Contact.

All six Local Place areas within South-West London have a multi-agency LeDeR Steering Group which meets quarterly to consider local reviews and recommendations and support work streams to turn actions into learning. As part of the LeDeR Governance Process there is a requirement for a Quality Assurance Panel, which quality checks completed reviews before they are presented at local steering groups, this panel has recently been set up with membership from across South-West London and representation from different professional groups.

Based on the findings from the 2022/23 Annual South-West London LeDeR report, there have been three priorities set for the new LeDeR Team:

- Aspiration Pneumonia alongside Respiratory Conditions was the leading cause of death for people with a learning disability in South-West London. A scoping exercise is to be undertaken to understand National and Local initiatives and establish a system wide approach to address this area of need.
- Deaths outside of hospital accounted for 24 out of the 86 deaths last year for people with a learning disability in South-West London, with their place of death being reported as home. 59 deaths occurred in hospital and whilst it may have been appropriate for these deaths to occur in hospital there will be a piece of work to understand if people were dying in their preferred place.
- There were no notifications of deaths of autistic people for South-West London last year. There were 11 notifications for people who had a dual diagnosis of a learning disability and autism. Reviewing deaths for people with an autism diagnosis is a new addition to the LeDeR Programme, as of 2022. It is believed that awareness of reporting deaths for this group is low and therefore an ICB wide awareness campaign is to be roll out to improve reporting and understand issues that affect people with autism.

The 2023/2024 LeDeR annual report is currently being drafted ready for publication in September 2024.

Richmond LeDeR data

The LeDeR Team at South-West London had 9 notifications on the LeDeR Platform of deaths of people with a learning disability who lived in the Borough of Richmond and whose deaths were reviewed. There were 3 Female and 6 Male cases. 7 people died in hospital and two in their own home. The main cause of death was aspiration pneumonia for 3 people, other causes of death included heart failure and sepsis.

Areas of good practice:

- Good reasonable adjustments in hospital settings,
- GP who was responsive to needs of care home residents.
- These were excellent examples of person-centred care provided to ensure health and wellbeing needs were met, whilst valuing opinions, wishes and feelings.
- Care Home Manager said that professionals in the Neuro Developmental Services of Your Health Care 'really do make an effort' and described them as 'absolutely fabulous.'

Recommendations:

- Care home training on recognising and managing deteriorating residents.

More details on LeDeR and programme reports, can be found on the South-West London ICB website.

Richmond and Wandsworth Safeguarding Adults Board

WANDSWORTH

327,506*
Borough population

30%
Black, Asian and Mixed Ethnicity

10%
Older people (65+)

Safeguarding in numbers – Safeguarding figures

Safeguarding Concerns and Enquiries

2023/24 saw an increase in both Concerns and enquiries for Wandsworth. The increase of enquiries by 26% is most likely linked to more individuals struggling with the cost of living and agencies knowing when to notify their concerns to the local authority. Additionally, there have been some issues in the way self-neglect concerns have been automatically triggered into safeguarding enquiry by the Front Door, Community Advice & Support team. This has been picked up with the team and Q4 data is already starting to show a downward trend. Other contributing factors include inappropriate referrals via the safeguarding online portal which by default will all trigger into safeguarding screening as this is first point of referral on Council websites. The websites have recently been updated to enable individuals and professionals to refer separately for advice and information and Care Act Assessment.

The proportion of enquiries relating to sex, age and ethnicity is consistent with the population of the Borough (Wandsworth has one of the highest proportions in London of younger adults 20-44-year-old; around 30% of the residents are Black, Asian or Minority Ethnic and the population is made up of 59% females and 41% males, with the proportion of females increasing with age).

62% of abuse takes place in an individual's own home, which reflects the fact most people live in their own home. Wandsworth has many care homes, including some of the biggest in the Country, and a number of hospitals in its territory, which reflect the second and third highest locations of abuse (17% and 8% respectively).

43% of safeguarding enquiries involved people who receive physical support. People with Mental Health support represent 20% of cases, followed by people with social support (14%) and people with Learning Disabilities (10%).

Richmond and Wandsworth Safeguarding Adults Board

Number of enquiries by abuse type

SELF-NEGLECT	NEGLECT / OMISSION	FINANCIAL / MATERIAL	PHYSICAL ABUSE	PSYCHOLOGICAL ABUSE	DOMESTIC VIOLENCE	SEXUAL	ORGANISATIONAL	DISCRIMINATORY	MODERN SLAVERY	RADICALISATION	TOTAL
24.0%	23.7%	14.6%	11.6%	11.4%	8.2%	3.4%	2.4%	0.6%	0.1%	0.0%	
275	271	167	133	130	94	39	27	7	1	0	1,144

Types of Abuse

Due to recent work around promoting recognition of self-neglect with partners and staff, for a time cases of self-neglect were automatically triggered into enquiries. This meant Self-neglect surpassed Neglect or Acts of Omission is the highest reported type of abuse in Wandsworth (up from 17% in 2022/23 to 24% in 2023/24), however in most cases a more preventative intervention was required when discussed at multi-agency meetings. They are followed by Financial/Material abuse and Physical abuse, similar to previous years. The RWSAB has raised awareness of the new Modern Slavery pathway in 2023/24, and we have seen some small rise in levels of Discriminatory Abuse, however numbers for it and for Modern Slavery continue to be low.

Making Safeguarding Personal

All agencies performing safeguarding duties are mandated by the Care Act of 2014 to implement Making Safeguarding Personal (MSP), a sector-led strategy that aims to develop outcomes focus to safeguarding work. This means that all safeguarding activities should be person-led, outcome-oriented, supportive of participation, choice, and control, enhance the individual's quality of life, and advance safety and well-being.

How well the person's desired outcomes are met is one of the key performance metrics of the Making Safeguarding Personal. Safeguarding practice is person-centred and adheres to MSP principles; locally, 81% of those participating in a Safeguarding Enquiry stated desired outcomes, and 95% of those outcomes were fully (75%) or partially (20%) met. When results are not expressed or not met, it is typically because the individual did not wish to participate in the process at the time of the inquiry.

All 129 people lacking capacity had support from family, friend or advocate during the Safeguarding process.

Concerns in 2023/24

3366

8% increase

(3104 in 2022/23)

Enquiries in 2023/24

1005

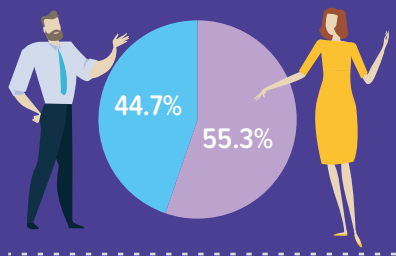
26% increase

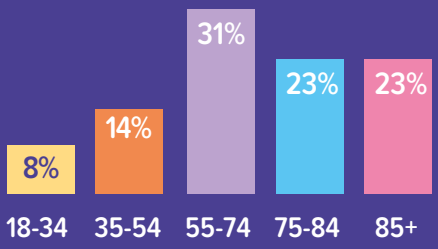
(797 in 2022/23)

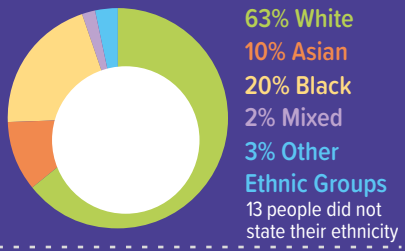
Conversion from concerns to enquiries

30%

26% in 2022/23







TYPES OF ABUSE

- **24%** (275) Self-neglect
- **24%** (271) Neglect
- **15%** (167) Financial/Material
- **12%** (133) Physical

62% (489) Own Home

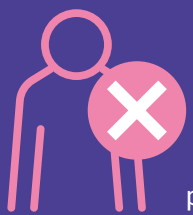
17% (131) Care Home Nursing and residential

8% (62) Hospital

30% 263) Known to Individual

7% (63) Care, health or other Professional

3% (30) Not known to Individual



59% (516) No alleged person recorded

81% (707) Expressed Desired Outcomes

95% (673) Outcome fully or partially achieved

85% (741) Felt safer after safeguarding

96% (658) Risk Reduced or removed

100% Support from advocate, family or friend

Case study*

Aubrey is a white British adult who is receiving support for her Mental Health. Concerns were first raised about Aubrey in summer 2023 by her mental health care coordinator, noting unusual behaviour and confusion and concerns over level of clutter which was having an impact in managing her daily living tasks. Aubrey was going outside at night not adequately dressed, saying she was trying to find her watch. The care coordinator noted Aubrey had difficulty taking her medication as prescribed and there were concerns that she wasn't getting adequate nutrition. Aubrey was assessed as lacking capacity relating to the safeguarding concerns and making decisions about her care and support, and so her brother was acting as her representative.

A multi-agency meeting was convened to gather all available information from the different agencies involved in helping Aubrey. Initially Aubrey's family were resisting external support as they felt, as her family, they should be providing Aubrey with support. The network worked with the family to develop a safety plan, to include providing Aubrey with a GPS Smart Watch and commissioning a deep clean to improve her home environment. London Fire Brigade also completed a home fire safety check. Aubrey's family continue to support her to attend medical appointments and have agreed to daily support via a Home-care agency to support her with personal care, nutrition, managing her medication and to maintain her environment. This has been successful in reducing the risks to Aubrey, she has gained weight and is no longer required to take nutritional supplements. Family have been able to continue providing a level of support to Aubrey and feel satisfied that she feels safe at home.

Aubrey's mother thanked the network for the help they have provided to Aubrey to make improvements for her, and stated that Aubrey was now doing well, and described the carers as "wonderful."

Aubrey's brother stated:

> "The care support Aubrey is receiving is much better than it had been in the past and there are now more avenues for her. Sincere thanks to the network for the work and support provided to Aubrey."

*names and details may be changed to preserve the anonymity of the people involved

Richmond and Wandsworth Safeguarding Adults Board

Impact on Risk and sense of safety

The London Borough of Wandsworth has continually asked people and/or their representatives about whether they felt safer as a result of the assistance received from those attending to the safeguarding enquiry. Out of 872 completed enquiries, 741 people (85%) expressed they felt safer after the process. In the remaining 131 (15%) cases, due to the nature of the concern and the impact on the person, the sense of safety has not improved for the person. These cases are monitored to ensure risk is managed.

The goal of adult safeguarding is to minimise or eliminate the risk to the adult. In 96% of cases, safeguarding reduced or removed the risk. Where the risk remains, it is typically because people have chosen to accept it and are aware of its consequences, with the cases monitored to ensure the risk is managed as well as possible.

Deprivation of Liberty Safeguards (DoLS)

The total number of DoLS authorisations received in Wandsworth has increased over the past year by 134, which shows a steady upward trajectory. Performance has increased with a rise in the number of authorisations granted. The number of not granted authorisations has also slightly increased, which demonstrates that most applications are appropriate – predominately authorisations not granted are as a result of people failing one of the qualifying assessments such as being assessed as having capacity or the person leaves hospital before the assessment process is completed or the person dies. A summary of the number of Deprivation of Liberty Safeguards requests and authorisations in Wandsworth during 2023/24 is shown below.

Community DoL

There will be more focus on Community DoL this year and currently there are 50 people in the community in Wandsworth whose needs are such that they meet the criteria for authorisation on deprivation of liberty. These individuals are regularly reviewed and with those with highest levels of restriction, authorisation is granted by the Courts.

Wandsworth DoLS	22/23	%	23/24	%	Change 2022/23 to 2023/24	
Granted	669	62.6%	757	62.8%	+87	+13%
Not Granted	315	29.5%	360	29.9%	+45	+14%
Not yet signed off by Supervisory Body	84	7.9%	88	7.3%	+2	+2%
Total Number of Requests Received	1068		1205		+134	

Provider Quality

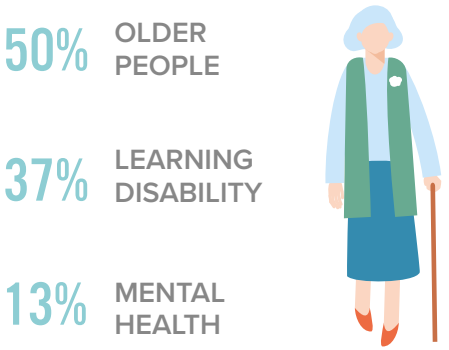
There are 30 Care Homes in Wandsworth, and 43 Care-at-home Services Providers which are registered with the care regulator the Care Quality Commission (CQC). 1 Care Home is Outstanding, 25 (83%) are rated Good, with 3 (10%) Requires Improvement and 1 not yet rated by the CQC. 3 of the Care-at-home Services Providers have been rated Outstanding, 31 (72%) Good, and 9 service has not been rated yet. Action plans and regular quality monitoring are in place to help improve ratings, as evident by the improved rating of the care-at-home service previously rated as Requires Improvement and now improved to Good. The service rated Inadequate has now closed. Overall quality of service provision for both Care Homes and Homecare providers across the borough remains good.

NOT YET RATED 3.3%

Care Homes CQC Rating (Wandsworth)	No	%
Outstanding	1	3.3%
Good	25	83.3%
Requires improvement	3	10%
Not yet rated	1	3.3%
Total	30	

INADEQUATE 0% - UNRATED SERVICE 21%

Care-at-home Services CQC Rating (Wandsworth)	No	%
Outstanding	3	7%
Good	31	72%
Requires improvement	0	0%
Inadequate	0	0%
Unrated service	9	21%
Total	43	



Care Home Type (Wandsworth)	No	%
Older people	15	50%
Learning disabilities	11	37%
Mental health	4	13%
Total	30	

Learning from Lives and Deaths of people with a Learning Disability and Autistic People

Following a restructure within South-West London ICB and recommendation from The LeDeR Policy (2021) to have a dedicated team of Reviewers, two full time permanent reviewers' roles have now been recruited to. The new LeDeR Manager has been in post since April 2024 and the LeDeR Officer is due to commence, in role, in June 2024. Overall governance of the SW London LeDeR Programme, at a strategic level, remains with the Chief Nurse and Director for Quality, who assigns the day-to-day operational management to the Local Area Contact.

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The 2023/2024 LeDeR annual report is currently being drafted ready for publication in September 2024.

Wandsworth LeDeR data

The LeDeR Team at South-West London had 10 notifications on the LeDeR Platform of deaths of people with a learning disability that lived in the borough of Wandsworth and whose deaths were reviewed. There were 6 Female and 4 Male deaths. The main cause of death was aspiration pneumonia with other causes of death including, heart disease, frailty, sepsis and cardiac arrest.

Areas of good practice:

- Care home enabled person-centred approach, wishes, feelings and opinions were valued and considered to support an independent life as possible until the end.
- GP was reported as exceptional by the NOK and responsive to needs.
- Records demonstrated that good reasonable adjustments had been made throughout interactions with health and social care, extra time had been provided as well as responsive referrals.
- Behaviour care plan in place to manage behaviours which challenged.
- Good example of co-ordinated teamwork with nursing home and GP services to ensure wellbeing needs were met in a timely and responsive way.
- End of life care in the care home, everyone involved worked together to support death peacefully in own home.

Recommendations:

- The family felt on an admission to hospital the person should have had 1:1 support.
- Improved communication between care homes and hospital.

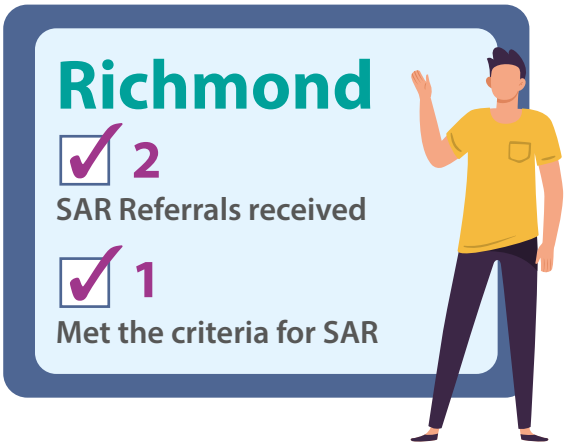
More details on LeDeR and programme reports, can be found on the South-West London ICB website.

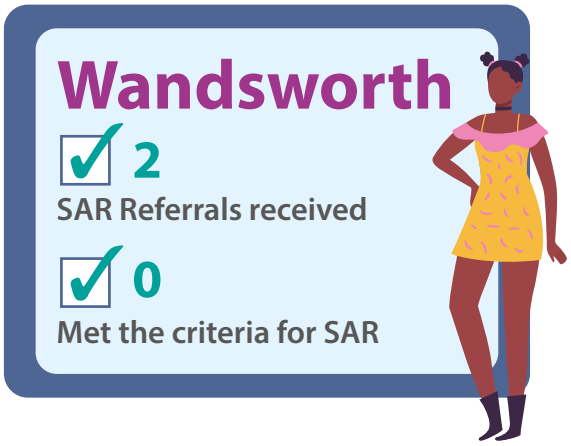
6

LEARNING FROM SAFEGUARDING ADULT REVIEWS

SAFEGUARDING ADULT REVIEW REFERRALS

During the year four Safeguarding Adult Reviews (SARs) referrals were considered (two from Richmond and two from Wandsworth), one of which met the criteria for a mandatory SAR (in Richmond).





The referrals received by the SAR Sub-group throughout the year showed multi-agency working was in place and good efforts were made to work with the persons and did not bring out any multi-agency concerns for learning.

A SAR concerning a young person aged 20 years-old which met the mandatory criteria is now complete, however the publication date has been postponed to not jeopardise other ongoing investigations and processes. The SAR involved transition from children to adult services and whilst learning from it has been taken forward, more details will be published once the other processes have completed.

The RWSAB noted that the Transition Panels and the new Transitions Pathway, had not been in place at the time. The Transitions Pathways and new Protocol were embedded across Children's and Adults' Social Care services after the person's sad death, and there are audits being conducted in 2024 to ensure improved practice. All audits' findings will be reported on to the RWSAB for oversight of any issues and assurance of good or improved practice.

Joint sessions are being planned across Children's and Adults' Services on Trauma-informed practice, with a multi-agency event planned for later in 2024, to facilitate better engagement and understanding of trauma on people's lives. RWSAB will also ask for an update from all partners on current training and compliance around Autism training, as this has been recognised in a couple of SARs so far as an issue.

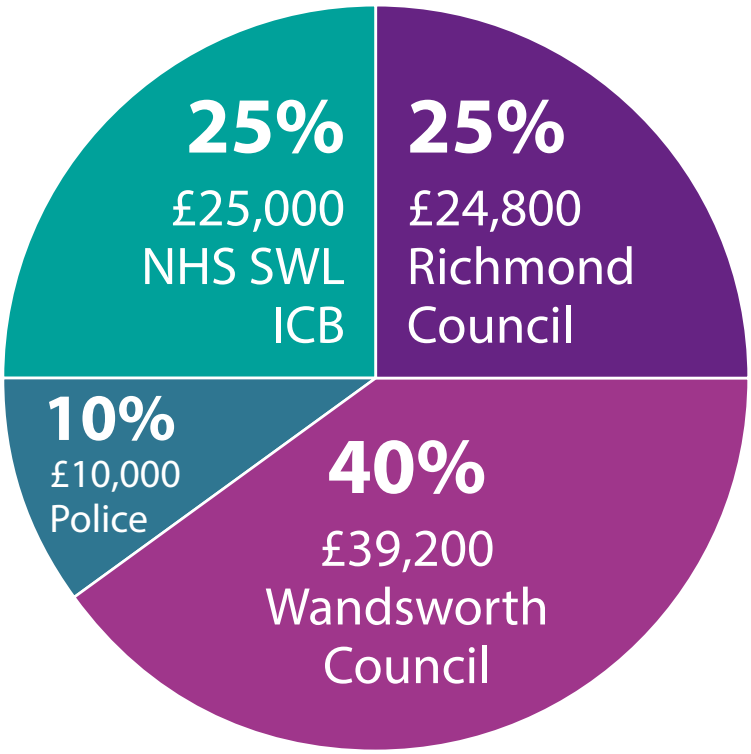
7

FINANCIAL SUMMARY

Whilst the primary responsibility for Safeguarding Adults rests with Richmond and with Wandsworth Councils, the key statutory partners are expected to contribute to the resources of the partnership on an equitable basis, to ensure effective safeguarding practices and responses.

As the below chart shows, Richmond and Wandsworth Councils funded 65% of the costs of the Richmond and Wandsworth Safeguarding Adults Board (RWSAB). South-West London Integrated Care Board and the Metropolitan Police also make a direct financial contribution. Discussions continue around moving to a more equitable distribution of funding between the three statutory partners of the RWSAB over time. In section 7 of this report are outlined some of the non-monetary contributions partners have made to safeguarding work in the boroughs of Richmond and Wandsworth.

Who gave money to the RWSAB?



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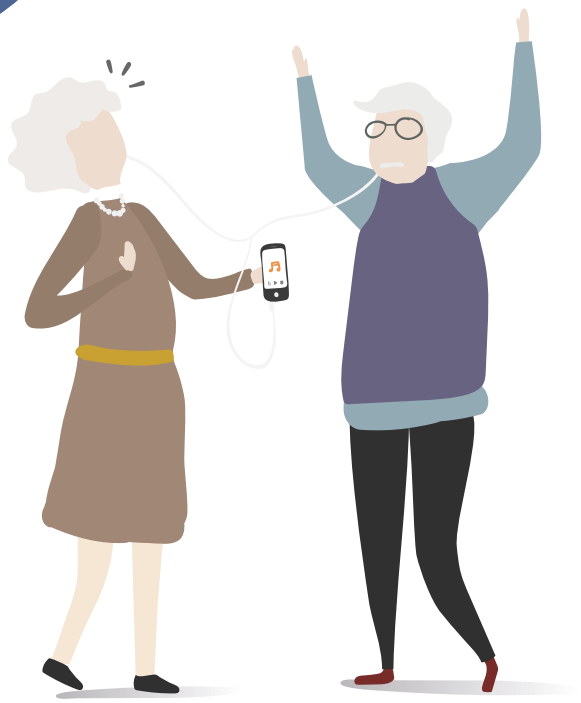
PARTNERS' CONTRIBUTIONS



Although Richmond and Wandsworth Councils lead on safeguarding adults in the Boroughs of Richmond and Wandsworth, all 33 partners contribute to our strategy. This section sets out how our partners went about achieving the aims and objectives of our strategic plan's main strands of Prevention and Early Intervention, Making Safeguarding Personal and Learning Lessons and Shaping Practice.

Adult Social Care – Richmond and Wandsworth Councils

Against a backdrop of significant system pressures including increased demand and complexity of need and rising costs, Adult Social Care and Public Health has delivered against the SAB's strategic plan in the following ways:

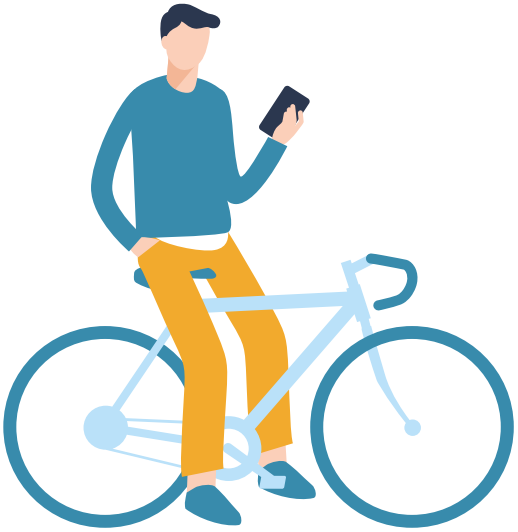
- We have a Prevention Framework for the boroughs which is an approach to embed choice, create supportive environments for our communities and make them health promoting as well.
- We have strengthened our approach towards those experiencing financial hardship through the roll out an extensive programme of cost-of-living support, to help lower-income families.
- There has been focus on carer's rights to assessment and support and promoting digital tech with carers.
- Right Care Right Person was implemented this year across both Councils with close oversight from partners to ensure any issues of concern are escalated swiftly. This is a national commitment from the Home Office, Department of Health & Social Care, the National Police Chiefs' Council, Association of Police and Crime Commissioners, and NHS England to work to end the inappropriate and avoidable involvement of Police in responding to incidents involving people with mental health needs. Where it is appropriate for the Police to be involved in responding, this must continue to happen.
- The Transitions Development Board which includes parent carer reps continues to set and monitor the priorities for young people in transition and focus on joined up work between Children's Services, Adult Social Care, Education, and the NHS. There are clear Transition pathways and robust tracking of young people in place. Additionally, there is more joined up working via the Vulnerable Adolescent Supported into Adulthood (Richmond) and Multiagency Child Exploitation panel (Wandsworth), to prevent the exploitation of young people.
- The relationship with Violence Against Women in both Boroughs strengthens via the operational and strategic groups and with a workforce across partnership attending tech abuse conference this year.
- Yearly monitoring of our safeguarding training compliance indicates good compliance across the Adult Social Care

workforce and there will be additional bitesize events to raise awareness of the Modern Slavery pathway.

- A deep dive was undertaken to look at the profile of rough sleepers where safeguarding concerns were triggered, to ensure appropriate sign posting and support is provided.
- Time was spent this year in looking back at completed Safeguarding Adult Reviews, to create discussions and reflections on practice.
- Our Refugee Service has been implemented to support sanctuary seeking residents and we are seeking Borough of Sanctuary Accreditation in both boroughs.
- We have implemented our Dementia Strategy in Richmond.
- We are developing a Public Mental Health Strategy for Wandsworth.
- There has been closer working with Wandsworth prison in ensuring appropriate response times for Care Act assessments to support prisoners with social care and health needs.

Age UK Wandsworth

Age UK Wandsworth continues to make safeguarding training a priority to promote good practice, prevention and early intervention . Staff complete refresher training on an annual basis and all Age UK Wandsworth volunteers complete safeguarding training as part of the recruitment and induction process.



Alzheimer's Society

The Alzheimer's Society have an internal Quality Safeguarding Team. We work with all directorates of our organisation and record, respond and report appropriately to the relevant statutory agencies where an adult or child may be at risk of abuse or neglect.

In order to work with Prevention and Early intervention, we work with our staff to signpost and support appropriately our service users to the relevant agencies and refer for care needs assessments/carers assessments for example. We have delivered a training session on exploring professional curiosity to our Dementia advisors on a quarterly basis, as well as understanding Mental Capacity monthly to help equip our workers and support with early intervention.

We understand how important making safeguarding personal is to those at risk. We aim to find out what the adult at risk's thoughts, views and wishes are, what they would like to happen as a result of a safeguarding referral, how it will support them and what other routes of support we can offer or signpost to, in order to get the best possible outcome. Where the person at risk does not have capacity, we aim to listen to their carer, find out if LPA is in place, look at best interest decisions and if it is needed to override consent to keep that person safe.

We are constantly shaping our practice from lessons learned. This may be for example through our serious incident process and Service Quality Reviews. Our internal team carry out 'safe' reviews on our Dementia Support services records to ensure policy and procedure has been followed along with quality assurance. This allows us to see where improvement can be made or also view best practice to share learning.

Richmond and Wandsworth Safeguarding Adults Board

Central London Community Healthcare Trust (CLCH)

CLCH work around Prevention and Early Intervention

- We supported the delivery of the Safeguarding Adult Board work and priorities, actively contributing to S42, S44 and S40 inquiries and CMARAP, MARAC and RWSAB sub-groups.
- We delivered safeguarding training to the Wandsworth staff, with over 95% of staff compliant with the required level of safeguarding training commensurate to their role.
- We delivered domestic abuse awareness sessions to staff on International Women's day (8th March 2024) using resources developed by the safeguarding team.
- We reviewed how we identify safety / safeguarding risks e.g., fire risk and promoted the use of risk assessments and referrals to London Fire and Rescue Service.
- The CLCH Pressure Ulcer Audit identified good practice regarding the use of risk assessments.

Making Safeguarding Personal

- We worked in partnership with our service users to achieve the outcomes they have identified and/or to work in their best interests to keep them safe.
- The CLCH annual conference included presentations from people with lived experience as well as national and CLCH speakers.
- We record patient stories and work with service users to get feedback
- Service users attend CLCH meetings where safeguarding / risk are discussed and reviewed.

Learning Lessons and practice change

- We successfully implemented the NHS England Patient Safety Incident Response Framework (PSIRF) and moved to reviewing incidents in a more timely way, to improve learning and patient safety.
- We have safe systems in place to report, track and monitor safeguarding incidents and concerns, with a Single Point of Contact in place so staff have access to timely advice and support.
- We have jointly trained practitioners working in Children or Adult Services to be 'think family' safeguarding champions.
- The focus of the CLCH Safeguarding Conference in October 2023 was: "Living with risk, Understanding Need, Preventing Harm".
- We launched the CLCH Safeguarding Journal Club in 2023 and have delivered sessions on mental capacity, consent and fire risk and safety, incorporating learning from local safeguarding cases and national reviews.
- We completed a second dip-sample of records to assure fire risk assessments for service users at increased risk were completed and referrals to London Fire Brigade are made.
- We use 7-minute briefings to share learning and change practice.
- We welcomed new team members.

Chelsea and Westminster NHS Foundation Trust

Prevention and Early Intervention

The Trust has seen an increase in the presentation of complex safeguarding cases with high risk of domestic abuse. The staff in the Trust have been aware of the signs of abuse. In order to support the patients, it is reassuring to know that staff are able to seek support from the Trust IDVA for support and appropriate referrals to services. Staff awareness of safeguarding has remained high across the Trust. A high number of referrals from the Trust are from the Accident and Emergency Department showing early identifications and appropriate interventions are implemented at the first point of contact to reduce risk before discharge if admitted into a ward or before discharge home.

Making Safeguarding Personal

The Safeguarding and Learning Disability Team across the Trust make sure that those with additional needs have a hospital passport on admission for their inpatient or outpatient appointments. The Staff are being encouraged when appropriate to seek the views and wishes of the individuals before making a referral to services. Staff are always being encouraged to ensure that they speak to the person and involve them in making decisions about their lives.

Learning Lessons and Shaping Practice

The Safeguarding Team have been producing a quarterly Trust wide newsletters to disseminate learning from Safeguarding Enquiries, Safeguarding Adults Reviews, and Practice Issues and provide up to date information about local training resources. The team contribute the Safeguarding Board activities across a number of local authorities. The Trust will continue with providing 7 minutes Learning newsletters through the Trust Bulletin. The Safeguarding team has a slot of induction to ensure staff are aware of the team and the important work the team does. The team are able to target departments with practice issues with appropriate training and guidance. The team is looking to utilise other medias in the Trust to disseminate the learning such as webinars and videos to support with the practice updates.

Community Safety continue to deliver the

Community Safety – Richmond and Wandsworth Councils

statutory responsibilities and implements guidance/ policies as set out in the Crime and Disorder Act, Domestic Abuse Act and other relevant legislation. The team is structured to provide both a reactive and proactive response against the below areas of priority of crime and disorder:

- Safer Neighbourhoods (high-volume crimes e.g., serious violence, anti-social behaviour, car related crimes).
- Violence against women and girls.
- Offender management.
- Hate crime and counter terrorism.
- Keeping children and young people safe.

Over the past year the Community Safety team has worked internally to create an effective funding structure and governance structure to appropriately respond to crime and disorder in the community; we have also refreshed our Community Safety Partnership Plans and local VAWG Strategy (Wandsworth). We have increased our local provisions with the expansion of the team through additional Community Safety Officers to lead a proactive and community led response to crime and disorder through problem solving plans and awareness raising.

The team provides reactive support, case panels and reviews, e.g., refuge, advocacy, DA MARAC, Community Triggers, CMARAC, DHRs. But also, proactive responses to priority issues e.g., violent crime forums, VAWG community forums, problem solving plans, task and finish, awareness raising, comms campaigns, training.

Healthwatch Richmond

Healthwatch Richmond has continued its role as a critical friend on the Board and sub-groups. We actively collaborate with partners to leverage their integrated communications and engagement capabilities. This strengthens our collective efforts to promote safeguarding messages and raise awareness within the community. We remain committed to the shared safeguarding objectives. We continue to make referrals, while also empowering members of the community to raise appropriate alerts.

Hounslow and Richmond Community Healthcare (HRCH)

In 2023-24 continuing pressures on community healthcare required responsive advice and support from the HRCH Adult Safeguarding team. To address the SAB priorities, we have:

- Reviewed and updated our intranet content to ensure all staff have access to up-to-date information and resources for prevention of harm, early intervention and making safeguarding personal to balance risk with rights.
- Added to our searchable library of 7-minute case summaries to enable achievable self-directed reflective practice on lessons learned for teams and added more short and powerful animations on emerging risk themes e.g. hypothermia.
- Recruited a full time Adult Safeguarding Specialist Nurse whose Workplan includes Team Talks (brief refresher re Safeguarding, consent and recording) and delivering training for Routine Enquiry about domestic abuse.
- Provided case by case advice and support to frontline staff, Managers and partners with regard to prevention of harm, risk assessment and our legal framework for action.
- Our work this year has positively impacted the experience and safety of many of our patients, their family carers and wider network.

Housing and Regeneration Department – Richmond and Wandsworth Councils

Housing are committed to the priorities of the SAB and look for ways to help achieve these. Central to this is the publication of our 2023-2028 Housing Strategy. As Richmond Council has no in-house housing stock, the team sits more suitably in the Wandsworth Community Forum of the RWSAB. Richmond is covered by the biggest Social Housing Provider Richmond Housing Partnership.

Supporting Vulnerable Residents is one of the key themes in our Strategy and sets out how Wandsworth will increase supply to meet the needs of vulnerable residents in Wandsworth and ensure that our existing residents can remain independent on their homes.

The department aims to participate constructively in partnership events, relevant sub-groups and multi-agency meetings to provide a housing perspective on issues and ensure policies and procedures reflect the priorities of the SAB and are up do date in addressing Safeguarding and meeting the needs of vulnerable residents.

The Housing and Regeneration Department are currently undergoing the assessment and accreditation process to continue their commitment to the Domestic Abuse Housing Alliance (DAHA).

Specialist courses in safeguarding adults and children is available for staff. New starters are required to complete their mandatory courses, which is monitored throughout the year.

Under the new housing regulatory regime, the department are focussed on seeking the views of, and meeting the needs of a diverse range of residents, to enable equal access to services and that resident voices are listened to. The publication of Wandsworth's new Housing Service Standards sets out these commitments for residents to hold the organisation to account.

This year Housing have developed or published procedures to strengthen our approach to vulnerable adults. This included updating our anti-social behaviour and noise nuisance procedures, our approach to building safety and developing a policy on identifying vulnerable adults, recording information and making reasonable service adjustments.

Kingston and Richmond Safeguarding Children Partnership (KRSCP)

During 2023-24 KRSCP have continued to promote our priorities of Contextual Safeguarding, Child Sexual Abuse, Mental Health, & Parental Vulnerabilities & Early Help through the work of the subgroups and boards. To support the commitment to engaging education as the fourth partner the Education Subgroup has been established and to ensure effective communicating with the Safeguarding Adult Boards for Kingston, and Richmond and Wandsworth, the Interface meetings have also been established. The KRSCP scrutineer has provided ongoing scrutiny of the work of the subgroups and section 11 audits have been undertaken to enable the partnership to scrutinise the safeguarding practice of partner agencies. KRSCP held a successful learning event on exploitation where we heard from experts by experience who told us of their journey of being exploited and helped us to consider how learning can be used to improve multi agency practice. As a result of themes identified from local child safeguarding practice reviews KRSCP undertook a month of targeted activity on child sexual abuse to raise awareness and support skills development across the partnership. With funding from public health KRSCP developed a film for parents regarding children and substance misuse and resources for schools. The KRSCP multi-agency safeguarding training offer has continued to raise awareness about both national and local safeguarding themes and disseminate learning from child safeguarding practice reviews across the partnership. With the publication of Working Together 2023 there is an expectation that the partnership review the governance and structure of KRSCP to meet the new requirements.

London Fire Brigade (LFB)

Richmond and Wandsworth Boroughs' London Fire Brigades work in partnership to identify, refer and assist the most vulnerable – assistance given in Home Fire Safety Visits (these are now prioritised and streamlined to target those at most risk,) fire retardant bedding and equipment supplied, alongside linked smoke detection (Tunstall alarms) and arson proof letter boxes. Attendance at the respective Richmond and Wandsworth Self-neglect and Hoarding Panels (previously 'VAMA' and 'CMARAP') and other relevant RWSAB meetings, including Multi-Agency Risk Assessment Framework meetings.

Providing training to frontline care staff in fire safety awareness and risks associated with clients. Setting up priority initiatives within the borough around Dementia, Alzheimer, Bluebird Care. Giving advice where appropriate to partners in the borough. More recently engagement with Age UK and more awareness of the assistance that LFB can give to those who are at risk. In Wandsworth there is an initiative with local housing to support carers with regards to the assistance they require and also guidance for those residents that don't have care packages.

Metropolitan Police South-West Basic Command Unit (SW BCU)

Quality Assurance

The South West BCU have robust systems in place to ensure quality, including a triage system within the Multi-Agency Safeguarding Hub. Force wide 'Vulnerability' training was rolled in 2022-23 and continues with all new recruits and ongoing refresher training to front-line staff. This training supports our officers to take a trauma informed approach to dealing with vulnerability and assist officers to identify vulnerable adults in the community. The force ensures a focus on vulnerability and that Protecting the vulnerable is front and centre of our force response. In addition, we are providing bespoke training sessions to our force control room call takers to ensure they can recognise and respond to vulnerability at the first point of contact and get it right. All our leadership courses for newly promoted Sergeants and Inspectors also includes an input on the strands of vulnerability which includes vulnerable adults.

Domestic Abuse and Serious Sexual Assault

The SW BCU Domestic abuse investigation teams have been working tirelessly across the BCU to reduce the level of domestic violence, this has been achieved in conjunction with partners agencies, supporting victims and providing specialist advice and safeguarding whilst targeting offenders. The SW Serious Sexual Assault investigation teams (RASSO) continue to improve how they operate, following the best practice and methodology borne out of the Soteria Bluestone research nationally. At the end of the financial year 2023-2024, the RASSO teams improved their performance significantly from previous years.

This approach provides an enhanced understanding of the lived experience of victim-survivors experiences of rape and sexual assault, establishing 5 pillars defining what "good" policing practice looks like, which emphasises:

1. a suspect-focused investigation
2. the disruption of and challenging of repeat offenders
3. embedding a systematic procedural justice to victim engagement during the investigative process
4. an enhanced, specialised officer learning and development programme, sensitive to officer wellbeing joined up seamlessly with the challenges of rape and serious sexual offences (RASSO) complaints in force as well as academic evidence drawn from a variety of disciplines
5. using data-led, performance-savvy monitoring and evaluation of new investigative strategies and justice outcomes, to improve understanding of RASSO reporting and outcomes

This year has seen the launch of the LEPH link (Law Enforcement and Public Health Link). This is accessible to each officer via their PDA, it is designed to support front line officers with access to the public health information they need at the click of a button. During interactions it provides a bespoke Public Health resource to assist police officers to raise awareness, motivate and signpost people to help them to improve their health and wellbeing covering a wide range of issues.

Operation Vigilant is the MPS's response to violence against women and girls within the evening and night-time economy. As well as the traditional high visibility policing, preventative action has been taken with specially trained officers deployed within key areas to identify predatory behaviour, with early intervention.

Key Activities

Right Care Right Person

The MPS/SW BCU are following national best practice and implementing Right Care Right Person (RCRP). This will reduce longer term demand by ensuring the public are directed to the right agency at the first point of contact. Since RCRP was launched on the 1st of November 2023, the MPS deployment to RCRP related calls has reduced from 41% to 29%, compared to the same period in 2022. This will continue over the next year where we look to roll out a consistent version of RCRP nationally. We are currently awaiting a national partnership agreement at government level which will agree the threshold of risk for calls for service which police need to attend. Throughout this implementation we have maintained close working relationships with our partner agencies including our mental health trusts, hospitals, and social care to ensure that we will only withdraw from some of these calls for service when they are ready and equipped to step in to support the individuals involved.

Communication and engagement

We continue to work closely with the multi-agency partnerships and have shared learning and training over the last year in relation to the growing concerns of children and young people in the transitional period involved in serious youth violence. Our multi agency exploitation hub has attended partnership CPD days to deliver inputs on exploitation and this offer continues to be extended to support the understanding and identification of exploitation.

Metropolitan Police South-West Basic Command Unit (SW BCU) - continued

Challenges:

We continue to face challenges alongside partners in achieving the best joint working possible, however, there is a willingness to do this as it is accepted that no one agency can act alone. We have revisited our interview suites across the force and made significant adaptations being cognisant of recommendations made from a trauma informed and neurodiversity perspective.

We are running daily triage meetings discussing all adult at risk cases. This is proving to be highly effective in assessing risk and improving investigation standards but also is providing an excellent platform for learning.

Other issues faced in 2023-2024:

- Potential demand exceeding available resources, particularly specialist resources.
- Understanding that adult-at-risk investigations are often complex and potentially increasing due to a number of socio-economic factors, such as more elderly people living in the community being cared for by family or friends or people who have "befriended" the adult at risk posing risk of intended or unintended abuse and/or neglect

National Probation Service

Staff are required to complete the mandatory Safeguarding Adults internal e-learning training on a rolling basis.

Where they meet the criteria, victims of all forms of exploitation can be supported, via our Victim Contact Scheme. Vulnerable adults are identified at every stage of contact with Probation including from pre-sentence at Court to community/prison engagement.

During supervision, people on Probation are referred and signposted by practitioners to relevant agencies for support. We have increased the use of our bespoke commissioned personal well-being service to support vulnerable adults. Significant concerns about safeguarding adults can be escalated for multi-agency management through MAPPA where necessary.

Richmond and Wandsworth Safeguarding Adults Board

Richmond Carers Centre

Prevention & Early Intervention

- All staff are trained to support carers with minimising the risk of abuse and signpost to support services/referrals where needed to avoid escalation of concerns. All signposts and referrals are recorded and reported quarterly.
- RCC runs a counselling service for unpaid carers, where there has been a request for support around more complex emotional needs. The counselling offer has increased in capacity over 2023/24 to support with early intervention.

Making Safeguarding Personal

- In addition to mandatory safeguarding training, as part of their ongoing professional development, all staff are expected to access additional training courses to support in their knowledge and understanding. RCC is committed to staff development and learning.

Learning lessons and shaping practice

- Safeguarding policy reviewed October 2023 and next review scheduled for October 2024.
- Internal safeguarding audit was conducted by trustees and SLT in February 2024 with recommendations for action as part of good practice. This will be scheduled annually.
- Awarded Excellence for Carers Award by Carers Trust in May 2024, which looks at good practice of the organisation including in relation to safeguarding adults, review of the policy, practices and procedures in place, and staff understanding of these.
- RCC has now updated the DBS checking procedure to include trustees and volunteers. This has been rolled out over 2023-2024 and reflected in the policies.
- RCC has provided for social care staff to access inductions regarding the services available.

Richmond Council for Voluntary Services (CVS)

Richmond CVS is the commissioned infrastructure organisation for the borough supporting the voluntary and community sector in all aspects of their activity. Our primary function relating to safeguarding adults at risk is to promote an environment where not for profit organisations and their governance structures, understand their responsibilities, have effective policies and procedures in place, feel confident in their knowledge and updated in their learning, and know how to respond where there is a concern.

We continue to support the principle that "Safeguarding is everybody's business" regardless of the type of charitable activity delivered. This year we have worked with 16 groups on a 1.1 basis to develop or update adult at risk safeguarding policies and procedures and answer queries relating to DBS check eligibility and implementation. The groups operate across a wide range of activity such as environment, arts and heritage, bereavement and counselling as well as health and social care. We have supported the sector in the transition to the new SAB online training in January 2024, and provided sector specific training to trustees.

Our membership of the Richmond Safeguarding Community Forum enables us to benefit from the collective wisdom and insight of community partners, and we highlight the trends and challenges we are seeing at a grassroots level and the profile of particularly vulnerable groups. This helps to raise awareness and inform practice, contributing to the continuous cycle of improvement, which we share with the sector.

Richmond Housing Partnership (RHP)

At RHP we're committed to ensuring that everyone who lives in one of our homes or uses our services is supported. As part of National Safeguarding Week in November 2023, our employees attended Safeguarding events held by Richmond Council as well as some facilitated by us. These focussed on raising awareness of the importance of safeguarding.

Safeguarding training is mandatory for all employees who work with customers, and this is supported by sharing case studies of safeguarding referrals.

We continue to support multi-agency working and interventions by building strong partnerships with local authorities, social services, and the Police. Regular information sharing, joint risk assessments, and coordinated action plans have been established to address concerns such as cuckooing (exploitation of vulnerable adults' homes for criminal activities) and drug-related activities involving vulnerable adults.

Richmond and Wandsworth Safeguarding Adults Board

South-West London and St. George's Mental Health Trust

SWL St George's Mental Health Trust's work around Prevention and Early Intervention:

- Domestic Violence and Abuse Advisor offering a targeted response and training across SWLSTG.
- We have developed a new co-produced domestic abuse policy for patients; new co-produced domestic policy for staff who may be experiencing domestic abuse.
- We have a implemented a new internal MARAC protocol.
- Hosted a safeguarding learning event for internal and external colleagues in recognition of National Safeguarding Adults Week.
- Hosted a domestic abuse conference on 29th November 2023 for internal and external colleagues in recognition of the 16 days of Activism.
- Created safeguarding training guide to support staff with thinking creatively about their learning.
- Developed various guidance and toolkits to support good safeguarding practice (Decision Making Tool).

Making Safeguarding Personal:

- Making safeguarding personal has been centre to all our safeguarding work. All policy and strategic projects are subject to principles of co-production to ensure listening to service user voice is embedded in practice.
- Current co-production projects include sexual safety working group, domestic violence and abuse strategy group, restrictive practice group.
- Representation at ESM by expert by experience to support organisational governance maintains MSP at the core of decision making.
- Safeguarding Adult Lead working collaboratively with patient group & involvement Team.

Learning Lessons and practice change:

- SAR recommendations are uploaded to Ulysses with nominated senior manager responsible for implementation of key learning.
- Bi-monthly Executive Safeguarding Meeting (ESM) and weekly/monthly Quality Matters meetings will identify key learning points and themes. These are disseminated down to the Service Lines.
- Where indicated, PSIRF Investigations are used to inform SAR reviews. PSIRF reports are subject to SI Panel Review and key learning points can be identified.
- We were involved in a SAR, the themes SWLSTG identified around effective communication with partner agencies at the earliest opportunity, making safeguarding personal and assessing MCA. We used the learning from this SAR to drive change and improvement in our systems.
- MCA recording system is currently being improved, working with the physical health team within trust to develop a robust response to self-neglect (physical health).

South-West London Integrated Care Board (SWL ICB) – Richmond and Wandsworth Councils

In July 2023, SWL ICB appointed a new Chief Nursing Officer (CNO) who is the ICB Executive Lead for Safeguarding. The SWL ICB Directors of Quality are statutory members of the R&W Executive SAB which provides statutory leadership and direction to the SAB, ensuring a strategic oversight. In addition to supporting the RWSAB the ICB Safeguarding Team reports to the SWL Quality Oversight Management Group which is chaired by the CNO and oversees the quality and safeguarding functions of the ICB. This reports to the Quality Performance Oversight Committee. This key role of this group is to ratify, check and challenge safeguarding and quality functions of SWL ICB.

Richmond and Kingston have a joint Quality Delivery Group which receives quarterly place safeguarding updates from the designates.

Richmond

The Richmond Designated Safeguarding Adults Nurse is an active member of all the RWSAB's subgroups and chairs the Richmond Community Forum.

To support prevention, the Richmond designate attends the Richmond VAMA Panel and advises and assists with health issues in specific cases. The designate also attends the Richmond Joint ICB & LA Provider Risk Panel which monitors concerns regarding care homes and community providers.

The designate attends Richmond statutory SAR and DHR panels and supports GP practices if health information is required for any of these reviews.

The Kingston and Richmond Named Safeguarding GP facilitates quarterly safeguarding training forums online for the local safeguarding GPs in Kingston and Richmond. These are supported by the adult and children designates. These are always very well attended and presentations in 23/24 included: Learning from SARs, Multi-Agency Risk Assessment Conferences (MARAC), the IRIS Programme (Specialist Domestic Violence programme for Primary Care) and Learning Disability updates from the LeDeR programme (learning from the lives and deaths of people with learning disabilities and autistic people).

Throughout the year the safeguarding designate and the named GP take many calls and queries from GPs regarding all types of safeguarding concerns with their patients. Every effort is made to give responsive and supportive advice and to ensure there is a 'making safeguarding personal' approach.

The designate also supports the ICB Richmond Continuing Health Care (CHC) team with any safeguarding concerns. The CHC team provide care and support to people with complex health needs.

The designated safeguarding adults and children professionals across SWL ICB work cohesively together and each lead on a safeguarding priority which includes Domestic Abuse and Sexual Violence, Violence Against Women and Girls, Serious Violence Duty, MCA & DoLS, Prevent and LeDeR to ensure the delivery of the national and local safeguarding priorities together with the RWSAB and Community Safety Partnership Boards (CSPB).

The designate completed and presented the Richmond SAPAT audit and presented this at the SAB challenge event which took place in February 2024. The Director of Quality and the designate supported and attended the RWSAB AGM which took place in March.

Wandsworth

The Wandsworth Designated Safeguarding Adults Professional is an active member of the RWSAB's sub-groups and chairs the Wandsworth Community Forum. During the year the ICB has contributed by having external guests to speak or presented specific topics to the board, for example the Engagement and Equalities Lead for SWL ICB did a presentation on the engagement approach for the NHS Joint Forward Plan with emphasis on primary care and prevention and how to engage with those people who would not engage with services in Wandsworth and also those with lived experience. The Head of Quality also shared a presentation on Patient Safety Incident Response Framework (PSIRF) which is the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. There was wider discussion around the virtual wards which allow patients to get the care they need at home safely and conveniently rather than being in hospital. Working together with other wider relevant agencies and the Local Authority to ensure a good outcome and response to keep the service user safe and as a result, raising awareness and having other Modern Slavery organisations such as Hestia to discuss this subject in our community forum.

As an active member on the statutory panels such as SARs and DHRs, the Wandsworth Joint Intelligent Group (WJIG), the Community Safety Partnership Boards (VRUs), and the Prevent and Protect Strategic group, the designated safeguarding adults professional contributes and helps ensuring that action plans, recommendations are completed in a timely manner and lessons learnt are shared with relevant agencies such as Primary Care to promote learning and shaping practice across SWL and beyond.

Good practice, recommendations and lessons learnt are also shared with our RWSAB to ensure that people with Learning Disabilities and autistic people have equal access to healthcare and improving services as detailed in the learning from the lives and deaths of people with learning disabilities and autistic people.

The strategic safeguarding priorities are jointly developed by the RWSAB and the SWL ICB designated safeguarding adult's professional following the challenge events from the SAPAT and at the RWSAB AGM in March 2024.

The designated safeguarding adults and children professionals across SWL ICB work cohesively together and each lead on a safeguarding priority which include Domestic Abuse and Sexual Violence, Violence Against Women and Girls, Serious Violence Duty, DHRs/SARs, MCA & DoLS, Prevent and LeDeR to ensure the delivery of the national and local safeguarding priorities together with our RWSAB and Community Safety Partnership Boards (CSPB).

St. George's University Hospital NHS Foundation Trust (StGH)

St George's University Hospital NHS Trust is a major trauma centre with additional regional specialist centres. This enables people from all over the UK to receive treatment within the Trust; and in turn results in Trust staff liaising with teams across multiple local authorities both within and outside of London.

Our key achievements in 2023/24 are:

- We worked in partnership with community partners to achieve positive outcomes for people accessing our services
- We contributed to Safeguarding Enquiries, CMARAP, MARAC, High Intensity User Groups, and SAB sub-groups
- Standardised adult safeguarding templates were created for use across the Trust. The referral templates emphasis the need for Making Safeguarding Personal
- Safeguarding, Mental Capacity, and Domestic Abuse Champion programs were introduced to enhance learning and additional support for clinical teams
- We updated our training packages to include learning from enquiries and SARs
- We updated the Adult Safeguarding, Mental Capacity Act and Deprivation of Liberty Safeguards, and Domestic Abuse policies to ensure that they were up to date and user friendly to shape ongoing practice
- Bespoke training offered to areas across the Trust. This training included clinical area specific case studies to make the training relevant to the area
- We developed closer links with the Learning Disability Service
- We extended the roles of the clinicians within the service to ensure that they are able to practice within and provide specialist support for adult safeguarding and mental capacity

Richmond and Wandsworth Safeguarding Adults Board

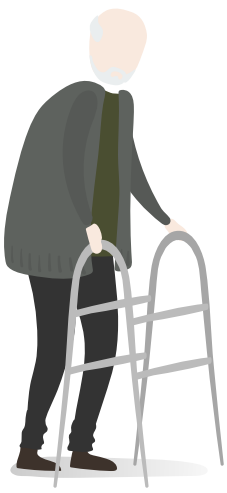
Trading Standards – Richmond and Wandsworth (part of the Regulatory Services Partnership)

We have continued to take a pro-active approach regarding scams. Attending several community events to speak with residents about their concerns providing advice on individual issues. As well as continuing our partnerships with many local organisations. Working with them to deliver educational talks and workshops to their service users.

When complaints have been received, we have provided advice and reassurance to residents helping them not to feel embarrassed or scared, ensuring they can continue to live independently. Where appropriate we have assisted them in obtaining refunds. This work has helped return over £75,000 to residents.

Wandsworth Care Alliance (WCA) and Healthwatch Wandsworth

Wandsworth Care Alliance continues to comply with our local Safeguarding policy (including in its Healthwatch Wandsworth activities). The policy is in line with Wandsworth Council's policies and procedures of Safeguarding Adults and Children. We have had no safeguarding activities beyond the routine maintenance and implementation of our safeguarding policy and governance. WCA staff and volunteers continue to participate with the Adults' and Children's Safeguarding boards from time to time.



Wandsworth Safeguarding Children Partnership (WSCP)

Over the past twelve months, the WSCP has continued to strengthen its partnerships, creating a more robust and cohesive framework. The WSCP operates through well-defined working groups, including the Training and Assurance Group and the LSCPR Sub-group, which report to our Operational and Executive groups.

These regular meetings ensure close collaboration and the development of plans to improve the lives of children in Wandsworth and imbed learning into practice. Strong knowledge of available community support allows for early intervention and engagement. Hearing firsthand about the safeguarding needs in the community enables us to respond more effectively. With this is mind we have reviewed our escalation policy and continued to imbed the continued work of our independent scrutineer.

Working with our partners in Health, Police, and Education, we aim to create safer environments for children at home, in school, and within the community, striving to provide them with the best possible outcomes.

We are currently in progress of reviewing one child in the CSPR Process and Adults Services have been a positive addition to the review of this child and our intervention.

In November 2023 Childrens Services and Adults services hosting a joint annual Conference with the focus of Anti Racist Practice in the borough. There were successes in delivering a dynamic systemic approach to evoking thought provoking conversations and stems to improve practice particularly when working with children and families that are black and brown from the global majority.

This year, the WSCP has reviewed and is actively working on delivering its Key Priorities. One significant focus is Anti-Racist Practice. We have established an Anti-Racist Practice Working Group, co-chaired by Children's Services and Police colleagues. This group collaborates with partners to ensure that children from global majority backgrounds receive the same level of care, intervention, and opportunities as all children in the borough.

In November 2023, the WSCP held its multi-agency Annual Conference with the theme of Anti-Racist Practice. The conference featured excellent speakers and was the first major initiative in delivering this priority, receiving a very positive response.

Over the past year, the WSCP has undergone several changes, including reviewing priorities, restructuring, and management changes. Recognizing the importance of understanding our families and community, we have increased voluntary and community sector representation on our working groups.

Our collaborative efforts to enhance the safety, wellbeing, and opportunities for all children in Wandsworth.

Your Healthcare (YH)

Your Healthcare is a direct provider of both health and social care, and, as such, adult safeguarding is an integral part of our service provision. By developing positive relationships with service users, their family and carers, our staff are well placed to identify potential safeguards. Our staff training programme equips practitioners to identify and respond to concerns. This includes early intervention through multi-agency working, and quality concern processes, as well as, escalation through reporting safeguards.

Your Healthcare is a long-standing member of the Safeguarding Adult Partnership Boards (SABs) in both Kingston and Richmond and, as such, we are committed members of sub groups and working groups which report into those Boards. The nine key safeguarding principles are embedded across the organisation, from our staff contracts of employment to our governance structures and individual or group supervision.

In 2023, Your Healthcare implemented the new NHS patient safety model. Patient Safety is the avoidance of unintended or unexpected harm to people during the provision of healthcare. Such incidents have the potential to meet the threshold of neglect as defined in the Care Act. This model takes a system learning approach which feeds into the adult safeguarding objectives around embedding learning into practice to reduce risk.

Following on from safeguards, we have the additional learning from Serious Adult Reviews (SAR). As one of the organisations involved in a SAR, the learning is evidenced directly from the action plan. Where we receive SAR reports not related to our services, we review these in order to take and share learning from the findings. Learning is primarily shared through training, 7-minute learning briefs and/or staff guidance, but implications to practice can be varied. Examples of this include: a review of the 'Was Not Brought' Policy to consider disguised compliance risk factors and where service users reliant on others to support them may miss appointments. Also, Your Healthcare has joined the Vulnerable Adolescents Support into Adulthood (VASA) Panel and reviewed its guidance to staff around identifying and responding to risk of suicide.

Your Healthcare is committed to working with partners in promoting the work of the Safeguarding Partnership Board and to continued development of safeguarding in practice.

Richmond and Wandsworth Safeguarding Adults Board

REPORTING A SAFEGUARDING CONCERN

Richmond

Phone
020 8891 7971

Out of hours
020 8744 2442

Email: adultsocialcare@richmond.gov.uk

Wandsworth

Phone
020 8871 7707

Out of hours
020 8871 6000

Email: adultsocialcare@wandsworth.gov.uk

Emergency

Call the Police or emergency services

999

Questions about this report

If you have any questions about this report, please email sab@richmondandwandsworth.gov.uk

Remember, safeguarding is everyone's business

Richmond and Wandsworth
Safeguarding Adults Board

Designed and produced by Richmond and Wandsworth Design and Print. wdp@wandsworth.gov.uk CS1975 (8.24)